EXHIBIT 72

Form **5500**
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210-0110
1210-0089

2001

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2001 or fiscal plan year beginning _____ and ending _____

A This return/report is for: (1) [ ] a multiemployer plan; (2) [X] a single-employer plan (other than a multiple-employer plan); (3) [ ] a multiple-employer plan; or (4) [ ] a DFE (specify) _____

B This return/report is: (1) [ ] the first return/report filed for the plan; (2) [ ] an amended return/report; (3) [ ] the final return/report filed for the plan; (4) [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here ►

D If filing under an extension of time or the DFVC program, check box and attach required information (see instructions) ►

Part II Basic Plan Information -- enter all requested information.

1a Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

1b Three-digit plan number (PN) ► 002

1c Effective date of plan (mo., day, yr.) 04/01/1976

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

769 NORTHFIELD AVENUE

WEST ORANGE NJ 07052

2b Employer Identification Number (EIN) 22-2323990

2c Sponsor's telephone number 973-731-9442

2d Business code (see instructions) 621111

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

_____ 12/14/01
Signature of plan administrator Date

MARIO CRISCITO, M.D.
Typed or printed name of individual signing as plan administrator

_____ _____
Signature of employer/plan sponsor/DFE Date

MARIO CRISCITO, M.D.
Typed or printed name of individual signing as employer, plan sponsor or DFE as applicable

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v4.1 Form **5500** (2001)

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PLAINTIFF'S EXHIBIT
CRISCITO 15
12-4-09
FEDERAL 800-431-6989

3a Plan administrator's name and address (If same as plan sponsor, enter "Same")	Official Use Only
SAME	3b Administrator's EIN
	3c Administrator's telephone number

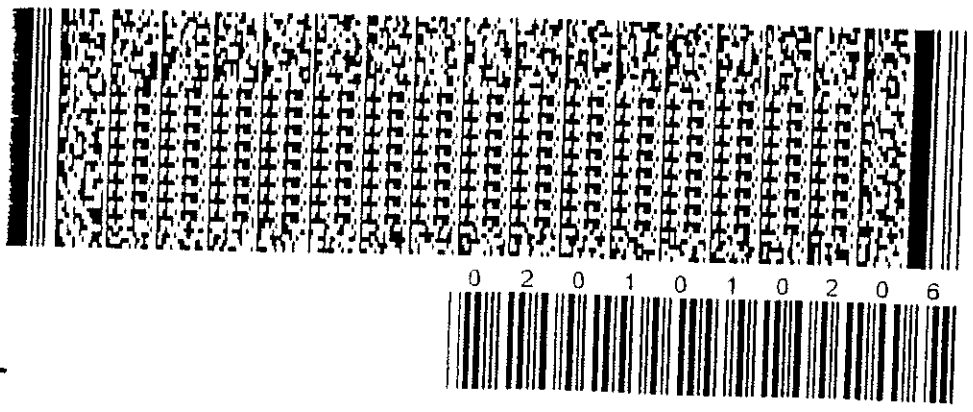
4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name — b EIN — c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address
AMERICAN PENSION CORPORATION
1375 PLAINFIELD AVENUE
WATCHUNG NJ 07069
b EIN 22-21411
c Telephone number 908-757-515

6 Total number of participants at the beginning of the plan year	6	2
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	24
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	1
d Subtotal. Add lines 7a, 7b, and 7c	7d	25
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	25
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	25
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	0

8 Benefits provided under the plan (complete 8a through 8c, as applicable)
a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2C 2R 3E
b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):
c [ ] Fringe benefits (check this box if the plan provides fringe benefits)

9a Plan funding arrangement (check all that apply)	9b Plan benefit arrangement (check all that apply)
(1) [X] Insurance	(1) [X] Insurance
(2) [ ] Code section 412(i) insurance contracts	(2) [ ] Code section 412(i) insurance contracts
(3) [X] Trust	(3) [X] Trust
(4) [ ] General assets of the sponsor	(4) [ ] General assets of the sponsor



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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid			
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid			
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid			
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

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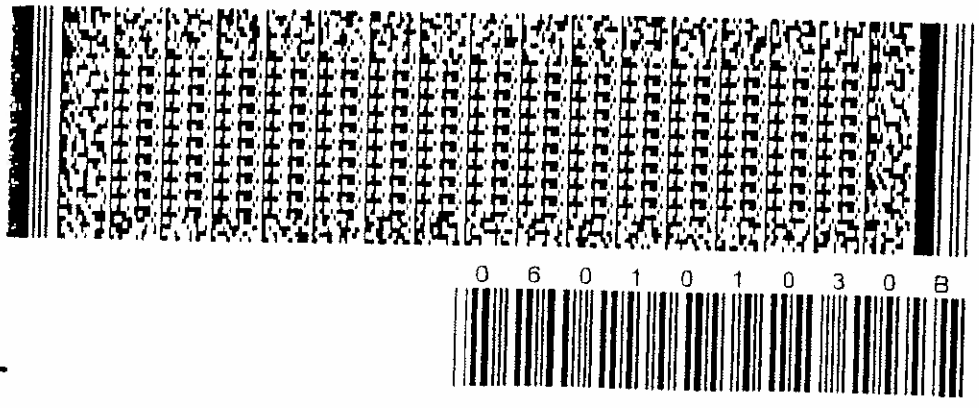
Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	
5	Contracts With Allocated Funds	
a	State the basis of premium rates ► ON FILE WITH THE DEPT. OF INS.	
b	Premiums paid to carrier	
c	Premiums due but unpaid at the end of the year	420
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	
	Specify nature of costs ► N/A	
e	Type of contract (1) [X] individual policies (2) [ ] group deferred annuity (3) [ ] other (specify) ►	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ► [ ]	
6	Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)	
a	Type of contract (1) [ ] deposit administration (2) [ ] immediate participation guarantee (3) [ ] guaranteed investment (4) [ ] other (specify below) ►	
b	Balance at the end of the previous year	
c	Additions: (1) Contributions deposited during the year	
	(2) Dividends and credits	
	(3) Interest credited during the year	
	(4) Transferred from separate account	
	(5) Other (specify below) ►	
	(6) Total additions	
d	Total of balance and additions (add b and c)6))	
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	
	(4) Other (specify below) ►	
	(5) Total deductions	
f	Balance at the end of the current year (subtract e (5) from d)	



Official Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) b ☐ Dental c ☐ Vision d ☐ Life Insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ Indemnity contrac
m ☐ Other (specify) ▶

8 Experience-rated contracts

a Premiums: (1) Amount received
(2) Increase (decrease) in amount due but unpaid
(3) Increase (decrease) in unearned premium reserve
(4) Earned ((1) + (2) - (3))

b Benefit charges: (1) Claims paid
(2) Increase (decrease) in claim reserves
(3) Incurred claims (add (1) and (2))
(4) Claims charged

c Remainder of premium: (1) Retention charges (on an accrual basis) --
(A) Commissions
(B) Administrative service or other fees
(C) Other specific acquisition costs
(D) Other expenses
(E) Taxes
(F) Charges for risks or other contingencies
(G) Other retention charges
(H) Total retention
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement
(2) Claim reserves
(3) Other reserves

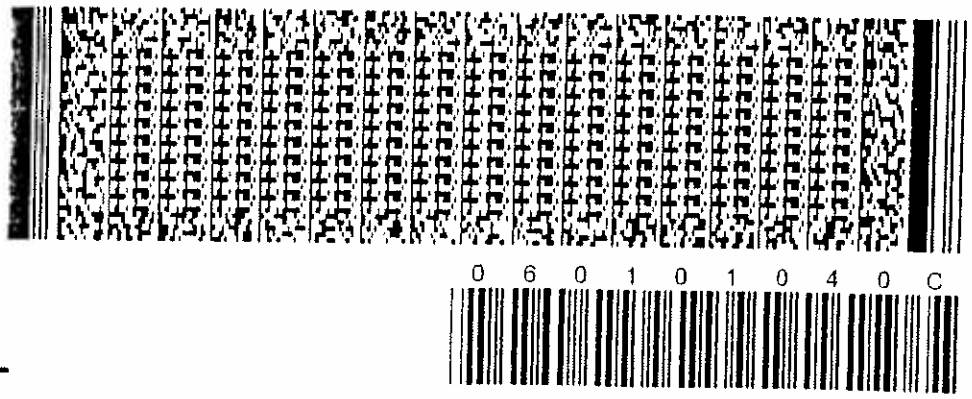
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)

9 Nonexperience-rated contracts:

a Total premiums or subscription charges paid to carrier

b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount

Specify nature of costs ▶



SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2001

This Form is Open to Public Inspection

For calendar year 2001 or fiscal plan year beginning and ending

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Part I **Information Concerning Insurance Contract Coverage, Fees, and Commissions**

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

PROVIDENT MUTUAL

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
		4024790	1	01/01/2001	12/31/2001

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commisions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid	Total fees paid / amount
0	0

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid			
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid			
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid			
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

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Part II **Investment and Annuity Contract Information**

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

Official Use Only

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates ► ON FILE WITH THE DEPT. OF INS.

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs ► N/A

e Type of contract (1) [X] individual policies (2) [ ] group deferred annuity
(3) [ ] other (specify) ►

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ► [ ]

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) [ ] deposit administration (2) [ ] immediate participation guarantee
(3) [ ] guaranteed investment (4) [ ] other (specify below) ►

b Balance at the end of the previous year

c Additions: (1) Contributions deposited during the year
(2) Dividends and credits
(3) Interest credited during the year
(4) Transferred from separate account
(5) Other (specify below) ►
(6) Total additions

d Total of balance and additions (add b and c)6))

e Deductions:
(1) Disbursed from fund to pay benefits or purchase annuities during year
(2) Administration charge made by carrier
(3) Transferred to separate account
(4) Other (specify below) ►
(5) Total deductions

f Balance at the end of the current year (subtract e (5) from d)

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Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) b ☐ Dental c ☐ Vision d ☐ Life Insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ Indemnity contrac
m ☐ Other (specify) ►

8 Experience-rated contracts		
a Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))		
b Benefit charges: (1) Claims paid		
(2) Increase (decrease) in claim reserves		
(3) Incurred claims (add (1) and (2))		
(4) Claims charged		
c Remainder of premium: (1) Retention charges (on an accrual basis) --		
(A) Commissions		
(B) Administrative service or other fees		
(C) Other specific acquisition costs		
(D) Other expenses		
(E) Taxes		
(F) Charges for risks or other contingencies		
(G) Other retention charges		
(H) Total retention		
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		
(2) Claim reserves		
(3) Other reserves		
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		
9 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		

Specify nature of costs ►

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SCHEDULE I (Form 5500)
Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2001

This Form is Open to Public Inspection.

For calendar year 2001 or fiscal plan year beginning , and ending .

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. **Round off amounts to the nearest dollar.**

			(a) Beginning of Year	(b) End of Year
1	**Plan Assets and Liabilities:**			
a	Total plan assets	1a	10,344,625	8,879,198
b	Total plan liabilities	1b		
c	Net plan assets (subtract line 1b from line 1a)	1c	10,344,625	8,879,198
2	**Income, Expenses, and Transfers for this Plan Year:**		(a) Amount	(b) Total
a	Contributions received or receivable			
	(1) Employers	2a(1)	472895	
	(2) Participants	2a(2)		
	(3) Others (including rollovers)	2a(3)		
b	Noncash contributions	2b		
c	Other income	2c	-1,938,322	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		-1,465,427
e	Benefits paid (including direct rollovers)	2e		
f	Corrective distributions (see instructions)	2f		
g	Certain deemed distributions of participant loans (see instructions)	2g		
h	Other expenses	2h		
i	Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		0
j	Net income (loss) (subtract line 2i from line 2d)	2j		-1,465,427
k	Transfers to (from) the plan (see instructions)	2k		

3 **Specific Assets:** If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

		Yes	No	Amount
a Partnership/joint venture interests	3a		X	
b Employer real property	3b		X	

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			Yes	No	Amount
3c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Transactions During Plan Year

4	During the plan year:		Yes	No	Amount
a	Did the employer fail to transmit to the plan any participant contributions within the maximum time period described in 29 CFR 2510.3-102? (See instructions)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Did the plan engage in any nonexempt transaction with any party-in-interest?	4d		X	
e	Was the plan covered by a fidelity bond?	4e	X		350000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report. (See instructions for conditions to be eligible for waiver.)	4k	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No **Amount**

5b If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

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SCHEDULE P (FORM 5500)

Department of the Treasury
Internal Revenue Service

Annual Return of Fiduciary of Employee Benefit Trust

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

▶ File as an attachment to Form 5500 or 5500-EZ.

Official Use Only

OMB No. 1210-0110

2001

This Form is Open to Public Inspection.

For trust calendar year 2001 or fiscal year beginning _____ and ending _____

1a Name of trustee or custodian

MARIO CRISCITO, M.D.

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

769 NORTHFIELD AVENUE

c City or town, state, and ZIP code

WEST ORANGE NJ 07052

2a Name of trust

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

b Trust's employer identification number 22-2323990

3 Name of plan if different from name of trust

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? ..... [X] Yes [ ] No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ ..... ▶ 22-2323990

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

Signature of fiduciary ▶ Date ▶

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.

v4.1

Schedule P (Form 5500) 200

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SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

OMB No. 1210-0110

2001

This Form is Open to Public Inspection.

For calendar year 2001 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions . . . . . 1 $

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). _____ _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? . . . . . ☐ Yes ☒ No ☐ N/A

If the plan is a defined benefit plan, go to line 7.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver . . . . . ▶ Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule B and do not complete the remainder of this schedule.

6a	Enter the minimum required contribution for this plan year	6a	$ 472895
b	Enter the amount contributed by the employer to the plan for this plan year	6b	$ 472895
c	Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	$ 0

If you completed line 6c, do not complete the remainder of this schedule.

7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? . . . . . ☐ Yes ☐ No ☐ N/A

Do not complete line 8, if the plan is a multiemployer plan or a plan with 100 or fewer participants during the prior plan year (see inst.).

8 Is the employer electing to compute minimum funding for this plan year using the transitional rule provided in Code section 412(l)(11) and ERISA section 302(d)(11)? . . . . . ☐ Yes ☐ No ☐ N/A

Part III Amendments

9 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) . . . . . ☐ Yes ☐ No

Official Use Only

SCHEDULE T (Form 5500)

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the Internal Revenue Code (the Code).

► File as an attachment to Form 5500.

OMB No 1210-0110

2001

This Form is Open to Public Inspection.

For calendar year 2001 or fiscal plan year beginning and ending

A Name of plan	B Three-digit plan number ►	
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN		002
C Plan sponsor's name as shown on line 2a of Form 5500	**D** Employer Identification Number	
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	22-2323990	

Note: If the plan is maintained by:

- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
- An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer	1b Employer identification number

2 If the employer maintaining the plan operates QSLOBs, enter the following information:

a The number of QSLOBs that the employer operates is _____

b The number of such QSLOBs that have employees benefiting under this plan is _____

c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ☐ Yes ☐ No

d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates.
►

3 Exceptions -- Check the box before each statement that describes the plan or the employer. Also see instructions.
If you check any box, do not complete the rest of this Schedule.

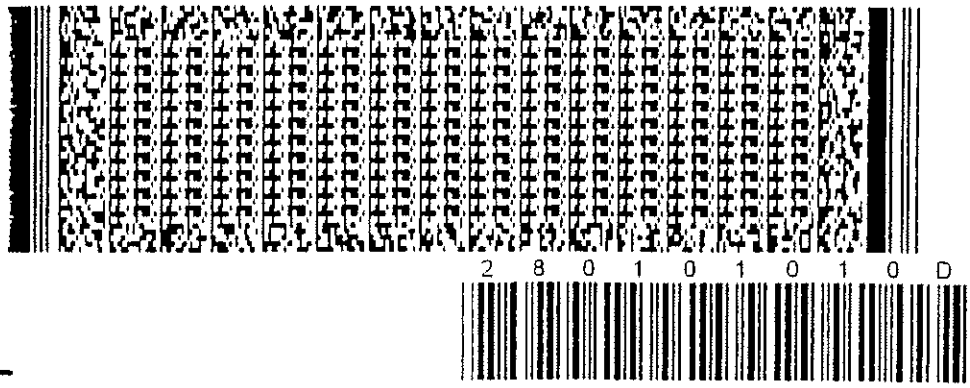
a ☐ The employer employs only highly compensated employees (HCEs).

b ☐ No HCEs benefited under the plan at anytime during the plan year.

c ☐ The plan benefits only collectively-bargained employees.

d ☐ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.

e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).



Official Use Only

4 Enter the date the plan year began for which coverage data is being submitted. Month 01 Day 01 Year 2001

a Did any leased employees perform services for the employer at any time during the plan year? ☐ Yes ☒ No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? ☐ Yes ☒ No

c Complete the following:

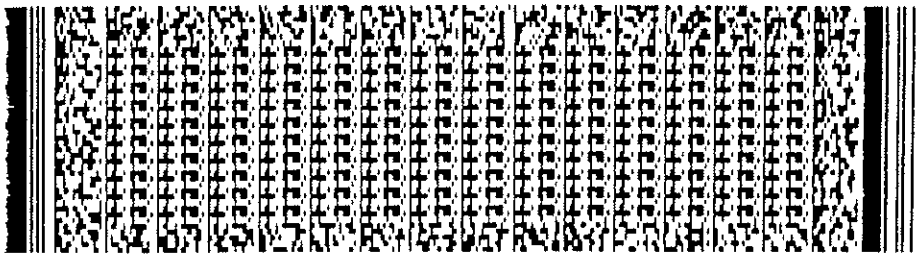
(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals	c(1)	24
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	0
(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))	c(3)	24
(4) Number of nonexcludable employees (line 4c(3)) who are HCEs	c(4)	12
(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan	c(5)	23
(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs	c(6)	12

d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) ▶ _____ d 91.7 %

e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

	Disaggregated part:	Ratio Percentage:	Exception:
(1)			
(2)			
(3)			

f This plan satisfies the coverage requirements on the basis of (check one): (1) ☒ the ratio percentage test (2) ☐ average benefit test



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(Rev. June 2001)
Department of the Treasury
Internal Revenue Service

To File Certain Employee Plan Returns

► For Paperwork Reduction Act Notice, see instructions on back.

File With IRS Only

File before the normal due date of the Form 5500, 5500-EZ, or 5330 (see instructions)

Name of filer, plan administrator, or plan sponsor (see instructions)
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

Number, street, and room or suite no. (If a P.O. box, see instructions.)
769 NORTHFIELD AVENUE

City or town, state, and ZIP code
WEST ORANGE, NJ 07052

Filer's Identifying Number—Check applicable box and enter number (see instructions).

[X] Employer identification number (EIN). Filers checking box 1a must enter an EIN. All other filers, see Specific Instructions.
► 22-2323990 OR

[ ] Social security number (see Specific Instructions)
►

1 I request an extension of time until 10 / 15 / 2002 (month / day / year) to file (check appropriate box(es)).

a [X] Form 5500 or 5500-EZ **(no more than 2½ months).**

The application is **automatically approved** to the date shown on line 1 (above) if: **(1)** box 1a is checked, **(2)** the Form 5558 is signed and filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and **(3)** the date on line 1 is no more than 2½ months after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed below.

b [ ] Form 5330 **(no more than 6 months).** Payment amount attached is $ _____ (see instructions)

2 Complete the following for the plan(s) covered by this application (see **How To File**):

Plan name/filer	Type of plan (check)			Plan number	Plan year ending		
	Pension	Welfare	Fringe		Month	Day	Year
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN				002	12	31	2001

3 State in detail why you need the extension (if line 1b is checked) _____

Under penalties of perjury, I declare that to the best of my knowledge and belief the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature ► John M. Cherlik Date ► [illegible]

Notice to Applicant

To Be Completed by the IRS if Line 1b Is Checked

To Be Completed by the IRS if line 1b is checked ▼

[ ] This application for extension to file Form 5330 **IS** approved to the date shown on line 1, if line 1b is checked. **(You must attach an approved copy of this form to each Form 5330 that was granted an extension.)**

[ ] The date entered on line 1 is more than the 6-month maximum time allowed for Form 5330. This application is approved to ..... **(You must attach an approved copy of this form to each Form 5330 that was granted an extension.)**

[ ] The application for an extension for Form 5330 **is not** approved, because it was filed after the normal due date of the return. **(A 10-day grace period is not granted.)**

[ ] This application for an extension for Form 5330 **is not** approved, because

- [ ] The application was not signed.
- [ ] No reason was given on this application or the reason was not acceptable.
- [ ] No payment was attached for the tax due on Form 5330.
- [ ] Other ► .....

A 10-day grace period is granted from the date shown below or the due date of the return, whichever is later. **(You must attach a copy of this form to each return you file that is granted a grace period.)**

_____ _____ By: _____
(Date) (Director)

Applicants for extension of Form 5330: Complete if you want this Form 5558 returned to an address other than the address shown above.

Please Print or Type

Name

Number, street, and room or suite no. (If a P.O. box, see instructions.)

City or town, state, and ZIP code

EXHIBIT 73

Form **5500**
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6039D, 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

▶ Complete all entries in accordance with the instructions to the Form 5500.

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Official Use Only
OMB Nos 1210-0110
1210-0089

2002

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For the calendar plan year 2002 or fiscal plan year beginning _____ and ending _____

A This return/report is for: (1) ☐ a multiemployer plan; (2) ☒ a single-employer plan (other than a multiple-employer plan); (3) ☐ a multiple-employer plan; or (4) ☐ a DFE (specify) _____

B This return/report is: (1) ☐ the first return/report filed for the plan; (2) ☐ an amended return/report; (3) ☐ the final return/report filed for the plan; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D If filing under an extension of time or the DFVC program, check box and attach required information (see instructions) ▶ ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

1b Three-digit plan number (PN) ▶ 002

1c Effective date of plan (mo., day, yr.) 04/01/1976

2a Plan sponsor's name and address (employer, if for a single-employer plan) (Address should include room or suite no.)
DIAGNOSTIC & CLINICAL CARDIOLOGY CARDIOLOGY, P.A.

769 NORTHFIELD AVENUE

WEST ORANGE NJ 07052

2b Employer Identification Number (EIN) 22-2323990

2c Sponsor's telephone number 973-731-9442

2d Business code (see instructions) 621111

[redacted]

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

SIGN HERE — Signature of plan administrator — Date 10/1/03 — MARIO CRISCITO, M.D. — Type or print name of individual signing as plan administrator

SIGN HERE — Signature of employer/plan sponsor/DFE — Date 10/1/03 — MARIO CRISCITO, M.D. — Type or print name of individual signing as employer, plan sponsor or DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v5.0 Form **5500** (2002)

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PLAINTIFF'S EXHIBIT
CRISCITO 16
12-4-09
FEIRGAD 800-631-6989

Form 5500 (2002) Page 2

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IRS Use Only

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address
AMERICAN PENSION CORPORATION

1375 PLAINFIELD AVENUE

WATCHUNG NJ 07069

b EIN
22-2141197

c Telephone number
908-757-5151

6 Total number of participants at the beginning of the plan year	6	33
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	30
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	2
d Subtotal. Add lines 7a, 7b, and 7c	7d	32
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	32
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	32
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	0

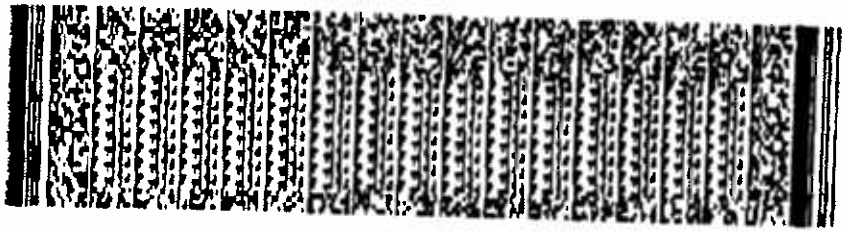
8 Benefits provided under the plan (complete 8a and 8b as applicable)

a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2C 2R 3E

b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(i) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
- (1) [X] Insurance
- (2) [ ] Code section 412(i) insurance contracts
- (3) [X] Trust
- (4) [ ] General assets of the sponsor



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Form 5500 (2002) Page 3

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10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a **Pension Benefit Schedules**

(1) [X] R (Retirement Plan Information)
(2) [X] 1 T (Qualified Pension Plan Coverage Information)
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
(3) [ ] B (Actuarial Information)
(4) [ ] E (ESOP Annual Information)
(5) [ ] SSA (Separated Vested Participant Information)

b **Financial Schedules**

(1) [ ] H (Financial Information)
(2) [X] I (Financial Information – Small Plan)
(3) [X] 2 A (Insurance Information)
(4) [ ] C (Service Provider Information)
(5) [ ] D (DFE/Participating Plan Information)
(6) [ ] G (Financial Transaction Schedules)
(7) [X] 1 P (Trust Fiduciary Information)

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M. [illegible]
11 Chadwick Rd
Livingston, N.J.
07039

PEBA
P.O. BOX 7043
LAWRENCE, KS 66044-7043

7 9 9 9 0 0 0 1 0 Z

Form **5558**
(Rev. June 2001)
Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

For Paperwork Reduction Act Notice, see instructions on back.

For IRS Only

File before the normal due date of the Form 5500, 5500-EZ, or 5330 (see instructions)

Name of filer, plan administrator, or plan sponsor (see instructions)
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

Number, street, and room or suite no. (If a P.O. box, see instructions.)
769 NORTHFIELD AVENUE

City or town, state, and ZIP code
WEST ORANGE, NJ 07052

Filer's Identifying Number—Check applicable box and enter number (see instructions).

☒ Employer identification number (EIN). Filers checking box 1a must enter an EIN. All other filers, see Specific Instructions. 22-2323990 OR

☐ Social security number (see Specific Instructions)

1 I request an extension of time until 10 / 15 / 2003 (month / day / year) to file (check appropriate box(es)).

a ☒ Form 5500 or 5500-EZ (no more than 2½ months).

The application is automatically approved to the date shown on line 1 (above) if: (1) box 1a is checked, (2) the Form 5558 is signed and filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and (3) the date on line 1 is no more than 2½ months after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed below.

b ☐ Form 5330 (no more than 6 months). Payment amount attached is $ _____ (see instructions)

2 Complete the following for the plan(s) covered by this application (see How To File):

Plan name/filer	Type of plan (check)			Plan number	Plan year ending		
	Pension	Welfare	Fringe		Month	Day	Year
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	X			002	12	31	2002

3 State in detail why you need the extension (if line 1b is checked) _____

Under penalties of perjury, I declare that to the best of my knowledge and belief the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

Signature John N. Chaplik Date JUL 11 2003

Notice to Applicant

To Be Completed by the IRS if Line 1b is Checked

To Be Completed by the IRS if line 1b is checked

☐ This application for extension to file Form 5330 IS approved to the date shown on line 1, if line 1b is checked. (You must attach an approved copy of this form to each Form 5330 that was granted an extension.)

☐ The date entered on line 1 is more than the 6-month maximum time allowed for Form 5330. This application is approved to _____ (You must attach an approved copy of this form to each Form 5330 that was granted an extension.)

☐ The application for an extension for Form 5330 is not approved, because it was filed after the normal due date of the return. (A 10-day grace period is not granted.)

☐ This application for an extension for Form 5330 is not approved, because

- ☐ The application was not signed.
- ☐ No reason was given on this application or the reason was not acceptable.
- ☐ No payment was attached for the tax due on Form 5330.
- ☐ Other _____

A 10-day grace period is granted from the date shown below or the due date of the return, whichever is later. (You must attach a copy of this form to each return you file that is granted a grace period.)

(Date) _____ (Director) _____ By: _____

Applicants for extension of Form 5330: Complete if you want this Form 5558 returned to an address other than the address shown above.

Please Print or Type

Name

Number, street, and room or suite no. (If a P.O. box, see instructions.)

City or town, state, and ZIP code

MGA

Form **5558** (Rev. 6-2001)

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SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection

For calendar year 2002 or fiscal plan year beginning and ending

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

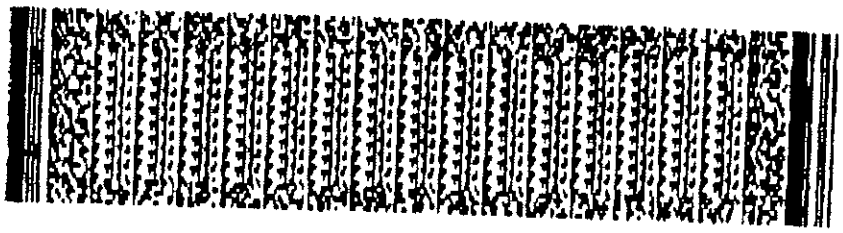
NEW YORK LIFE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
		P8102530	1	01/01/2002	12/31/2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid	Total fees paid / amount
0	0



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Schedule A (Form 5500) 2002 Page 2

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

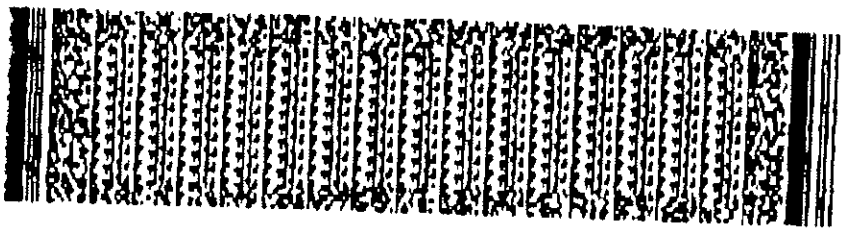
(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

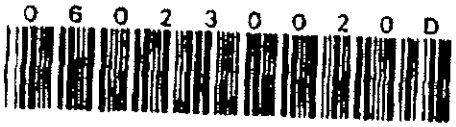
(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid		(e) Organization code
	(c) Amount	(d) Purpose	





Schedule A (Form 5500) 2002 Page 3

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Special Use Only

Part III Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates ▶ ON FILE WITH THE DEPT. OF INS.

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year 42006

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs ▶ N/A

e Type of contract (1) [X] individual policies (2) [ ] group deferred annuity
(3) [ ] other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ [ ]

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) [ ] deposit administration (2) [ ] immediate participation guarantee
(3) [ ] guaranteed investment (4) [ ] other (specify below)
▶

b Balance at the end of the previous year

c Additions: (1) Contributions deposited during the year

(2) Dividends and credits

(3) Interest credited during the year

(4) Transferred from separate account

(5) Other (specify below)
▶

(6) Total additions

d Total of balance and additions (add b and c)

e Deductions:

(1) Disbursed from fund to pay benefits or purchase annuities during year

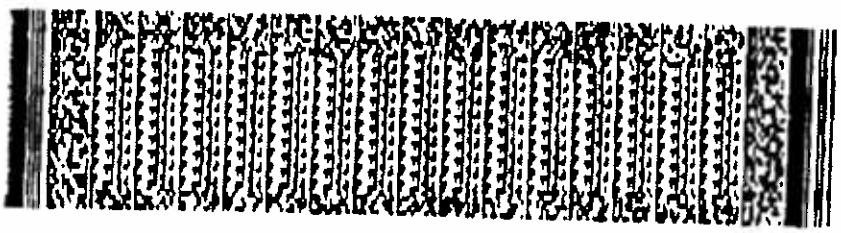
(2) Administration charge made by carrier

(3) Transferred to separate account

(4) Other (specify below)
▶

(5) Total deductions

f Balance at the end of the current year (subtract e(5) from d)



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Schedule A (Form 5500) 2002 Page 4

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Official Use Only

Part II Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) b ☐ Dental c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ Indemnity contract
m ☐ Other (specify) ▶

8 Experience-rated contracts:

a	Premiums: (1) Amount received	
	(2) Increase (decrease) in amount due but unpaid	
	(3) Increase (decrease) in unearned premium reserve	
	(4) Earned ((1) + (2) - (3))	
b	Benefit charges: (1) Claims paid	
	(2) Increase (decrease) in claim reserves	
	(3) Incurred claims (add (1) and (2))	
	(4) Claims charged	
c	Remainder of premium: (1) Retention charges (on an accrual basis) –	
	(A) Commissions	
	(B) Administrative service or other fees	
	(C) Other specific acquisition costs	
	(D) Other expenses	
	(E) Taxes	
	(F) Charges for risks or other contingencies	
	(G) Other retention charges	
	(H) Total retention	
	(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
	(2) Claim reserves	
	(3) Other reserves	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	

9 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	

Specify nature of costs ▶

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SCHEDULE A
(Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection

For calendar year 2002 or fiscal plan year beginning and ending

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

PROVIDENT MUTUAL

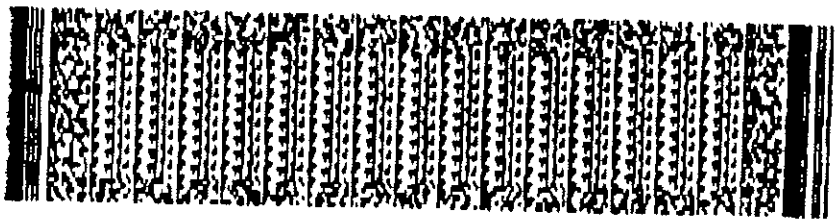
(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
		4024790	1	01/01/2002	12/31/2002

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part I.

Totals

Total amount of commissions paid	Total fees paid / amount
0	0

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v5.0 Schedule A (Form 5500) 2002



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Schedule A (Form 5500) 2002 Page 2

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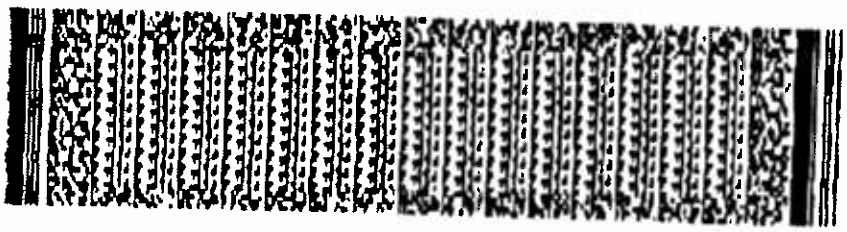
(Optional Use Only)

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	(b) Amount of commissions paid	Fees paid (c) Amount	Fees paid (d) Purpose	(e) Organization code

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	(b) Amount of commissions paid	Fees paid (c) Amount	Fees paid (d) Purpose	(e) Organization code

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid	(b) Amount of commissions paid	Fees paid (c) Amount	Fees paid (d) Purpose	(e) Organization code



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Schedule A (Form 5500) 2002 Page 3

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IRS Use Only

Part III Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3 Current value of plan's interest under this contract in the general account at year end

4 Current value of plan's interest under this contract in separate accounts at year end

5 Contracts With Allocated Funds

a State the basis of premium rates ▶ ON FILE WITH THE DEPT. OF INS.

b Premiums paid to carrier

c Premiums due but unpaid at the end of the year 0

d If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount

Specify nature of costs ▶ N/A

e Type of contract (1) [X] individual policies (2) [ ] group deferred annuity
(3) [ ] other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ [ ]

6 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract (1) [ ] deposit administration (2) [ ] immediate participation guarantee
(3) [ ] guaranteed investment (4) [ ] other (specify below)
▶

b Balance at the end of the previous year

c Additions: (1) Contributions deposited during the year
(2) Dividends and credits
(3) Interest credited during the year
(4) Transferred from separate account
(5) Other (specify below)
▶
(6) Total additions

d Total of balance and additions (add b and c)

e Deductions:
(1) Disbursed from fund to pay benefits or purchase annuities during year
(2) Administration charge made by carrier
(3) Transferred to separate account
(4) Other (specify below)
▶
(5) Total deductions

f Balance at the end of the current year (subtract e (5) from d)

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Schedule A (Form 5500) 2002 Page 4

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Optional Use Only

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes on this report.

7 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision)
b ☐ Dental
c ☐ Vision
d ☐ Life insurance
e ☐ Temporary disability (accident and sickness)
f ☐ Long-term disability
g ☐ Supplemental unemployment
h ☐ Prescription drug
i ☐ Stop loss (large deductible)
j ☐ HMO contract
k ☐ PPO contract
l ☐ Indemnity contract
m ☐ Other (specify) ▶

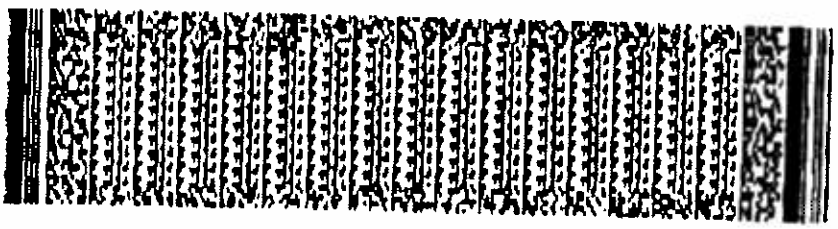
8 Experience-rated contracts

a	Premiums: (1) Amount received	
	(2) Increase (decrease) in amount due but unpaid	
	(3) Increase (decrease) in unearned premium reserve	
	(4) Earned ((1) + (2) - (3))	[redacted]
b	Benefit charges: (1) Claims paid	
	(2) Increase (decrease) in claim reserves	
	(3) Incurred claims (add (1) and (2))	[redacted]
	(4) Claims charged	
c	Remainder of premium: (1) Retention charges (on an accrual basis) –	
	(A) Commissions	
	(B) Administrative service or other fees	
	(C) Other specific acquisition costs	
	(D) Other expenses	
	(E) Taxes	[redacted]
	(F) Charges for risks or other contingencies	
	(G) Other retention charges	
	(H) Total retention	
	(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)	
d	Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement	
	(2) Claim reserves	
	(3) Other reserves	
e	Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)	

9 Nonexperience-rated contracts:

a	Total premiums or subscription charges paid to carrier	[redacted]
b	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount	

Specify nature of costs ▶



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SCHEDULE I (Form 5500)
Department of the Treasury
Internal Revenue Service
Department of Labor
Pension and Welfare Benefits Administration
Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

Part II Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

			(a) Beginning of Year	(b) End of Year
1	Plan Assets and Liabilities:			
a	Total plan assets	1a	8879198	8117946
b	Total plan liabilities	1b		
c	Net plan assets (subtract line 1b from line 1a)	1c	8879198	8117946
2	Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a	Contributions received or receivable			
	(1) Employers	2a(1)	619049	
	(2) Participants	2a(2)		
	(3) Others (including rollovers)	2a(3)		
b	Noncash contributions	2b		
c	Other income	2c	-1318968	
d	Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d	[redacted]	-699919
e	Benefits paid (including direct rollovers)	2e	19333	
f	Corrective distributions (see instructions)	2f		[redacted]
g	Certain deemed distributions of participant loans (see instructions)	2g		61333
h	Other expenses	2h	42000	
i	Total expenses (add lines 2e, 2f, 2g, and 2h)	2i	[redacted]	
j	Net income (loss) (subtract line 2i from line 2d)	2j	[redacted]	-761252
k	Transfers to (from) the plan (see instructions)	2k		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

			Yes	No	Amount
a	Partnership/joint venture interests	3a		X	
b	Employer real property	3b		X	

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Schedule I (Form 5500) 2002 Page 2

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		Yes	No	Amount
3c	Real estate (other than employer real property)		X	
d	Employer securities		X	
e	Participant loans		X	
f	Loans (other than to participants)		X	
g	Tangible personal property		X	

Part III Transactions During Plan Year

During the plan year:

		Yes	No	Amount
4a	Did the employer fail to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?		X	
d	Did the plan engage in any nonexempt transaction with any party-in-interest?		X	
e	Was the plan covered by a fidelity bond?	X		350000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No Amount

5b If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

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SCHEDULE P
(FORM 5500)

Department of the Treasury
Internal Revenue Service

Annual Return of Fiduciary of Employee Benefit Trust

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

▶ File as an attachment to Form 5500 or 5500-EZ.

IRS Use Only

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For trust calendar year 2002 or fiscal year beginning _____ and ending _____

1a Name of trustee or custodian

MARIO CRISCITO, M.D.

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

769 NORTHFIELD AVENUE

c City or town, state, and ZIP code

WEST ORANGE NJ 07052

2a Name of trust

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

b Trust's employer identification number 22-2323990

3 Name of plan if different from name of trust

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? ☒ Yes ☐ No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ ▶ 22-2323990

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

SIGN HERE Signature of fiduciary ▶ _____ Date ▶ 10/15/03

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.

v5.0

Schedule P (Form 5500) 2002

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Official Use Only

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Pension and Welfare Benefits Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

OMB No 1210-0110

2002

This Form is Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions ..... 1 $ [redacted]

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-2323990

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? ..... ☐ Yes ☐ No ☐ N/A
If the plan is a defined benefit plan, go to line 7.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver ..... ▶ Month _____ Day _____ Year _____
If you completed line 5, complete lines 9, 9, and 10 of Schedule B and do not complete the remainder of this schedule.

6a	Enter the minimum required contribution for this plan year	6a	$ 619049
b	Enter the amount contributed by the employer to the plan for this plan year	6b	$ 619049
c	Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	$ 0

If you completed line 6c, do not complete the remainder of this schedule.

7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☐ Yes ☐ No ☐ N/A

Part III Amendments

8 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) ..... ☐ Yes ☐ No

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IRS Use Only

SCHEDULE T (Form 5500)

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

OMB No. 1210-0110

2002

This Form is Open to Public Inspection.

For calendar year 2002 or fiscal plan year beginning _____ and ending _____

A Name of plan DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	B Three-digit plan number ▶ 002
C Plan sponsor's name as shown on line 2a of Form 5500 DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.	D Employer Identification Number 22-2323990

Note: If the plan is maintained by:

- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
- An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer.

1a Name of participating employer	1b Employer identification number

2 If the employer maintaining the plan operates QSLOBs, enter the following information:

a The number of QSLOBs that the employer operates is _____.

b The number of such QSLOBs that have employees benefiting under this plan is _____.

c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ... ☐ Yes ☐ No

d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates. ▶

3 Exceptions – Check the box before each statement that describes the plan or the employer. Also see instructions. If you check any box, do not complete the rest of this Schedule.

a ☐ The employer employs only highly compensated employees (HCEs).

b ☐ No HCEs benefited under the plan at anytime during the plan year.

c ☐ The plan benefits only collectively-bargained employees.

d ☐ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.

e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

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Schedule T (Form 5500) 2002 Page 2

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Official Use Only

4 Enter the date the plan year began for which coverage data is being submitted. Month 01 Day 01 Year 2002

a Did any leased employees perform services for the employer at any time during the plan year? ☐ Yes ☒ No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? ☐ Yes ☒ No

c Complete the following:

(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals	c(1)	32
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	0
(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))	c(3)	32
(4) Number of nonexcludable employees (line 4c(3)) who are HCEs	c(4)	13
(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan	c(5)	30
(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs	c(6)	13

d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) ▶ d 89.5 %

e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

	Disaggregated part:	Ratio Percentage:	Exception:
(1)			
(2)			
(3)			

f This plan satisfies the coverage requirements on the basis of (check one): (1) ☒ the ratio percentage test (2) ☐ average benefit test

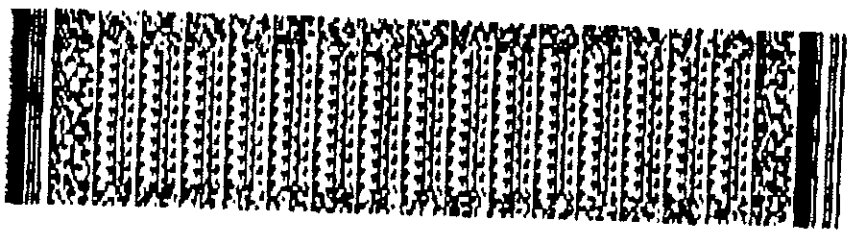

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EXHIBIT 74

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03

Form **5500**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210-0110
1210-0089

2003

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2003 or fiscal plan year beginning _____ and ending _____

A This return/report is for: (1) ☐ a multiemployer plan; (2) ☒ a single-employer plan (other than a multiple-employer plan); (3) ☐ a multiple-employer plan; or (4) ☐ a DFE (specify) _____

B This return/report is: (1) ☐ the first return/report filed for the plan; (2) ☐ an amended return/report; (3) ☐ the final return/report filed for the plan; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here ☐

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ► ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

1b Three-digit plan number (PN) ► 002

1c Effective date of plan (mo., day, yr.) 04/01/1976

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

769 NORTHFIELD AVENUE

WEST ORANGE NJ 07052

2b Employer Identification Number (EIN) 22-2323990

2c Sponsor's telephone number 973-731-9442

2d Business code (see instructions) 621111

[redacted]

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report if it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

SIGN HERE Signature of plan administrator 10/15/04 Date

MARIO CRISCITO, M.D.
Type or print name of individual signing as plan administrator

SIGN HERE Signature of employer/plan sponsor/DFE 10/15/04 Date

MARIO CRISCITO, M.D.
Type or print name of individual signing as employer, plan sponsor or DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v6.1 Form **5500** (2003)

PLAINTIFF'S EXHIBIT
CRISCITO 17
12-4-09

PENGAD 800-631-6989

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Form 5500 (2003) Page 2

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03

Official Use Only

3a Plan administrator's name and address (if same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address
AMERICAN PENSION CORPORATION

1375 PLAINFIELD AVENUE

WATCHUNG NJ 07069

b EIN
22-2141197

c Telephone number
908-757-5151

6 Total number of participants at the beginning of the plan year	6	43
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	38
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	4
d Subtotal. Add lines 7a, 7b, and 7c	7d	42
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	42
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	42
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	0

8 Benefits provided under the plan (complete 8a and 8b as applicable)

a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2C 2R 3E

b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)
(1) [X] Insurance
(2) [ ] Code section 412(i) insurance contracts
(3) [X] Trust
(4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
(1) [X] Insurance
(2) [ ] Code section 412(i) insurance contracts
(3) [X] Trust
(4) [ ] General assets of the sponsor

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Official Use Only

Form 5500 (2003) Page 3

10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

a Pension Benefit Schedules

(1) [X] R (Retirement Plan Information)
(2) [X] 1 T (Qualified Pension Plan Coverage Information)
If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶
(3) [ ] B (Actuarial Information)
(4) [ ] E (ESOP Annual Information)
(5) [ ] SSA (Separated Vested Participant Information)

b Financial Schedules

(1) [ ] H (Financial Information)
(2) [X] I (Financial Information – Small Plan)
(3) [X] 1 A (Insurance Information)
(4) [ ] C (Service Provider Information)
(5) [ ] D (DFE/Participating Plan Information)
(6) [ ] G (Financial Transaction Schedules)
(7) [X] 1 P (Trust Fiduciary Information)

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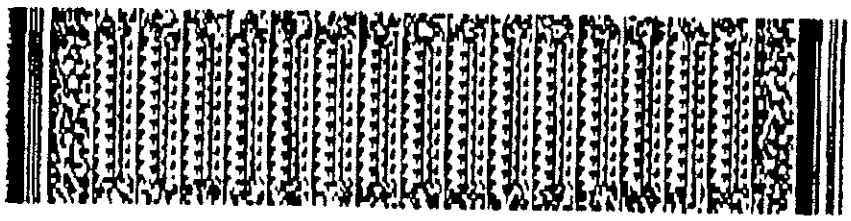

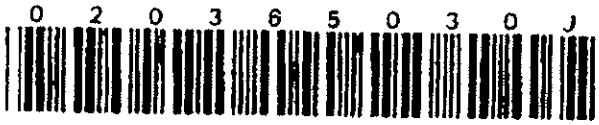

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Visito
32 Chelsea Dr.
Livingston NJ
07039

OCT 21 2004

PWBA
P.O BOX 7043
LAWRENCE, KS 66044-7043

66044x7043 59

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Form **5558** (Rev. June 2001)

Department of the Treasury
Internal Revenue Service

Application for Extension of Time To File Certain Employee Plan Returns

► For Paperwork Reduction Act Notice, see instructions on back.

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File With IRS Only

File before the normal due date of the Form 5500, 5500-EZ, or 5330 (see instructions)

Name of filer, plan administrator, or plan sponsor (see instructions)
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

Number, street, and room or suite no. (If a P.O. box, see instructions.)
769 NORTHFIELD AVENUE

City or town, state, and ZIP code
WEST ORANGE, NJ 07052

Filer's Identifying Number—Check applicable box and enter number (see instructions).

☒ Employer identification number (EIN). Filers checking box 1a must enter an EIN. All other filers, see Specific Instructions.
► 22-2323998 OR

☐ Social security number (see Specific Instructions)
►

1 I request an extension of time until 10 (month) / 15 (day) / 2004 (year) to file (check appropriate box(es)).

a ☒ Form 5500 or 5500-EZ (no more than 2½ months).

The application is automatically approved to the date shown on line 1 (above) if: (1) box 1a is checked, (2) the Form 5558 is signed and filed on or before the normal due date of Form 5500 or 5500-EZ for which this extension is requested, and (3) the date on line 1 is no more than 2½ months after the normal due date.

You must attach a copy of this Form 5558 to each Form 5500 and 5500-EZ filed after the due date for the plans listed below.

b ☐ Form 5330 (no more than 6 months). Payment amount attached is $ _____ (see instructions)

2 Complete the following for the plan(s) covered by this application (see *How To File*):

Plan name/filer	Type of plan (check)			Plan number	Plan year ending		
	Pension	Welfare	Fringe		Month	Day	Year
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN	X			0 0 2	12	31	2003

3 State in detail why you need the extension (if line 1b is checked) _____

Under penalties of perjury, I declare that to the best of my knowledge and belief the statements made on this form are true, correct, and complete, and that I am authorized to prepare this application.

John N. Chaplik

Signature ► John N. Chaplik Date ► 07/09/2004

Notice to Applicant

To Be Completed by the IRS if Line 1b Is Checked

To Be Completed by the IRS if line 1b is checked ▼

☐ This application for extension to file Form 5330 IS approved to the date shown on line 1, if line 1b is checked. (You must attach an approved copy of this form to each Form 5330 that was granted an extension.)

☐ The date entered on line 1 is more than the 6-month maximum time allowed for Form 5330. This application is approved to _____ (You must attach an approved copy of this form to each Form 5330 that was granted an extension.)

☐ The application for an extension for Form 5330 is not approved, because it was filed after the normal due date of the return. (A 10-day grace period is not granted.)

☐ This application for an extension for Form 5330 is not approved, because

- ☐ The application was not signed.
- ☐ No reason was given on this application or the reason was not acceptable.
- ☐ No payment was attached for the tax due on Form 5330.
- ☐ Other ► _____

A 10-day grace period is granted from the date shown below or the due date of the return, whichever is later. (You must attach a copy of this form to each return you file that is granted a grace period.)

_____ (Date) _____ (Director) By: _____

Applicants for extension of Form 5330: Complete if you want this Form 5558 returned to an address other than the address shown above.

Please Print or Type

Name

Number, street, and room or suite no. (If a P.O. box, see instructions.)

City or town, state, and ZIP code

MCA

Form **5558** (Rev. 6-2001)

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SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974.

▶ File as an attachment to Form 5500.

▶ Insurance companies are required to provide this information pursuant to ERISA section 103(a)(2).

Official Use Only

OMB No. 1210-0110

2003

This Form is Open to Public Inspection.

For calendar plan year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHAS

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number 22-2323990

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage:

(a) Name of insurance carrier

NEW YORK LIFE

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year (f) From	(g) To
		P8102530	1	01/01/2003	12/31/2003

2 Insurance fees and commissions paid to agents, brokers and other persons. Enter the total fees and total commissions below and list agents, brokers and other persons individually in descending order of the amount paid in the items on the following page(s) in Part II.

Totals

Total amount of commissions paid	Total fees paid / amount
0	0

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(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid (c) Amount	Fees paid (d) Purpose	(e) Organization code

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid (c) Amount	Fees paid (d) Purpose	(e) Organization code

(a) Name and address of the agents, brokers or other persons to whom commissions or fees were paid

(b) Amount of commissions paid	Fees paid (c) Amount	Fees paid (d) Purpose	(e) Organization code

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Schedule A (Form 5500) 2003 Page 3

Part III Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

3	Current value of plan's interest under this contract in the general account at year end	
4	Current value of plan's interest under this contract in separate accounts at year end	
5	Contracts With Allocated Funds	
a	State the basis of premium rates ▶ ON FILE WITH THE DEPT. OF INS.	
b	Premiums paid to carrier	42000
c	Premiums due but unpaid at the end of the year	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount	
	Specify nature of costs ▶ N/A	
e	Type of contract (1) [X] individual policies (2) [ ] group deferred annuity (3) [ ] other (specify) ▶	
f	If contract purchased, in whole or in part, to distribute benefits from a terminating plan check here ▶ [ ]	
6	*Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)*	
a	Type of contract (1) [ ] deposit administration (2) [ ] immediate participation guarantee (3) [ ] guaranteed investment (4) [ ] other (specify below) ▶	
b	Balance at the end of the previous year	
c	Additions: (1) Contributions deposited during the year	
	(2) Dividends and credits	
	(3) Interest credited during the year	
	(4) Transferred from separate account	
	(5) Other (specify below) ▶	
	(6) Total additions	
d	Total of balance and additions (add b and c (6))	
e	Deductions:	
	(1) Disbursed from fund to pay benefits or purchase annuities during year	
	(2) Administration charge made by carrier	
	(3) Transferred to separate account	
	(4) Other (specify below) ▶	
	(5) Total deductions	
f	Balance at the end of the current year (subtract e (5) from d)	

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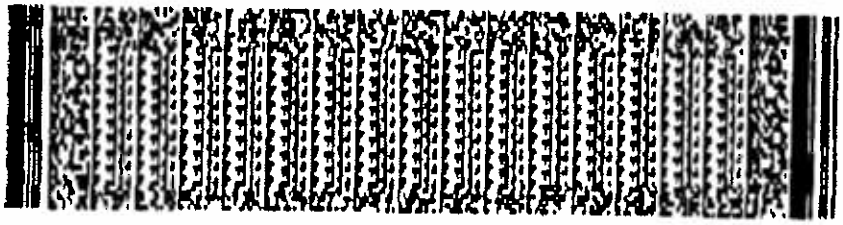

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Schedule A (Form 5500) 2003 Page 4

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organization(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

7 Benefit and contract type (check all applicable boxes)

a ☐ Health (other than dental or vision) b ☐ Dental c ☐ Vision d ☐ Life insurance
e ☐ Temporary disability (accident and sickness) f ☐ Long-term disability g ☐ Supplemental unemployment h ☐ Prescription drug
i ☐ Stop loss (large deductible) j ☐ HMO contract k ☐ PPO contract l ☐ Indemnity contract
m ☐ Other (specify) ▶

8 Experience-rated contracts		
a Premiums: (1) Amount received		
(2) Increase (decrease) in amount due but unpaid		
(3) Increase (decrease) in unearned premium reserve		
(4) Earned ((1) + (2) - (3))		
b Benefit charges: (1) Claims paid		
(2) Increase (decrease) in claim reserves		
(3) Incurred claims (add (1) and (2))		
(4) Claims charged		
c Remainder of premium: (1) Retention charges (on an accrual basis) –		
(A) Commissions		
(B) Administrative service or other fees		
(C) Other specific acquisition costs		
(D) Other expenses		
(E) Taxes		
(F) Charges for risks or other contingencies		
(G) Other retention charges		
(H) Total retention		
(2) Dividends or retroactive rate refunds. (These amounts were ☐ paid in cash, or ☐ credited.)		
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement		
(2) Claim reserves		
(3) Other reserves		
e Dividends or retroactive rate refunds due. (Do not include amount entered in c(2).)		
9 Nonexperience-rated contracts:		
a Total premiums or subscription charges paid to carrier		
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, item 2 above, report amount		

Specify nature of costs ▶

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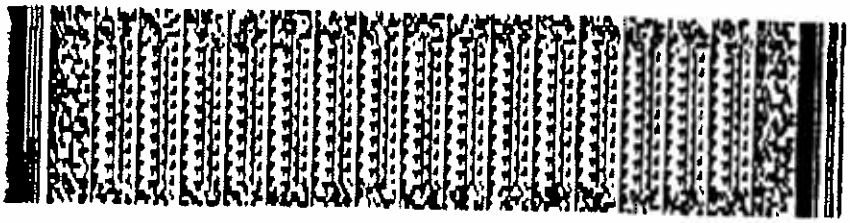

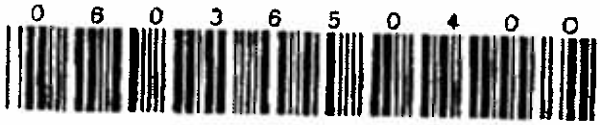

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SCHEDULE I (Form 5500)
Department of the Treasury
Internal Revenue Service
Department of Labor
Employee Benefits Security Administration
Pension Benefit Guaranty Corporation

Financial Information -- Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only
OMB No. 1210-0110
2003
This Form is Open to Public Inspection.

For calendar year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHA

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

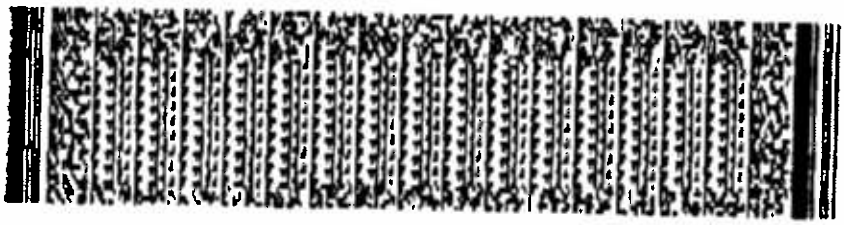
Part I Small Plan Financial Information

Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

		(a) Beginning of Year	(b) End of Year
1 Plan Assets and Liabilities:			
a Total plan assets	1a	8117946	8462930
b Total plan liabilities	1b	0	0
c Net plan assets (subtract line 1b from line 1a)	1c	8117946	8462930
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable: (1) Employers	2a(1)	720018	[redacted]
(2) Participants	2a(2)		
(3) Others (including rollovers)	2a(3)		
b Noncash contributions	2b		
c Other income	2c	-316903	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d	[redacted]	403115
e Benefits paid (including direct rollovers)	2e	16131	[redacted]
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Other expenses	2h	42000	
i Total expenses (add lines 2e, 2f, 2g, and 2h)	2i	[redacted]	58131
j Net income (loss) (subtract line 2i from line 2d)	2j		344984
k Transfers to (from) the plan (see instructions)	2k		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

		Yes	No	Amount
a Partnership/joint venture interests	3a		X	
b Employer real property	3b		X	



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Schedule I (Form 5500) 2003 Page 2

			Yes	No	Amount
3c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part III Transactions During Plan Year

During the plan year:

			Yes	No	Amount
4a	Did the employer fail to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e	Was the plan covered by a fidelity bond?	4e	X		350000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No Amount

5b If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

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SCHEDULE P
(FORM 5500)

Department of the Treasury
Internal Revenue Service

Annual Return of Fiduciary of Employee Benefit Trust

This schedule may be filed to satisfy the requirements under section 6033(a) for an annual information return from every section 401(a) organization exempt from tax under section 501(a).

Filing this form will start the running of the statute of limitations under section 6501(a) for any trust described in section 401(a) that is exempt from tax under section 501(a).

▶ File as an attachment to Form 5500 or 5500-EZ.

Official Use Only

OMB No. 1210-0110

2003

This Form is Open to Public Inspection.

For trust calendar year 2003 or fiscal year beginning _____ and ending _____

1a Name of trustee or custodian

MARIO CRISCITO, M.D.

b Number, street, and room or suite no. (If a P.O. box, see the instructions for Form 5500 or 5500-EZ.)

769 NORTHFIELD AVENUE

c City or town, state, and ZIP code

WEST ORANGE NJ 07052

2a Name of trust

DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

b Trust's employer identification number 22-2323990

3 Name of plan if different from name of trust

4 Have you furnished the participating employee benefit plan(s) with the trust financial information required to be reported by the plan(s)? ☒ Yes ☐ No

5 Enter the plan sponsor's employer identification number as shown on Form 5500 or 5500-EZ ▶ 22-2323990

Under penalties of perjury, I declare that I have examined this schedule, and to the best of my knowledge and belief it is true, correct, and complete.

SIGN HERE Signature of fiduciary ▶ _____ Date ▶ 10/15/04

For the Paperwork Reduction Notice and OMB Control Numbers, see the instructions for Form 5500 or 5500-EZ.

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Schedule P (Form 5500) 2003

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Official Use Only

SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

OMB No. 1210-0110

2003

This Form is Open to Public Inspection.

For calendar year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHAS

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number 22-2323990

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions . . . . . 1 $ [redacted]

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). 22-2323990

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year 3

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? . . . . . ☐ Yes ☒ No ☐ N/A
If the plan is a defined benefit plan, go to line 7.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver . . . . . ▶ Month _____ Day _____ Year _____
If you completed line 5, complete lines 9, 9, and 10 of Schedule B and do not complete the remainder of this schedule.

6a	Enter the minimum required contribution for this plan year	6a	$ 720018
b	Enter the amount contributed by the employer to the plan for this plan year	6b	$ 720018
c	Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	$ 0

If you completed line 6c, do not complete the remainder of this schedule.

7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? . . . . . ☐ Yes ☐ No ☐ N/A

Part III Amendments

8 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) . . . . . ☐ Yes ☐ No

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Official Use Only

OMB No. 1210-0110

SCHEDULE T (Form 5500)

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the Internal Revenue Code (the Code).

► File as an attachment to Form 5500.

2003

This Form is Open to Public Inspection.

For calendar year 2003 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE

B Three-digit plan number ► 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number 22-2323990

Note: If the plan is maintained by:

- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
- An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer

1b Employer identification number

2 If the employer maintaining the plan operates QSLOBs, enter the following information:

a The number of QSLOBs that the employer operates is _____.

b The number of such QSLOBs that have employees benefiting under this plan is _____.

c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ☐ Yes ☐ No

d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates. ►

3 Exceptions – Check the box before each statement that describes the plan or the employer. Also see instructions.
If you check any box, do not complete the rest of this Schedule.

a ☐ The employer employs only highly compensated employees (HCEs)

b ☐ No HCEs benefited under the plan at anytime during the plan year.

c ☐ The plan benefits only collectively-bargained employees.

d ☐ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.

e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(6)(C).

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Official Use Only

Schedule T (Form 5500) 2003 Page 2

4 Enter the date the plan year began for which coverage data is being submitted. Month 01 Day 01 Year 2003

a Did any leased employees perform services for the employer at any time during the plan year? ☐ Yes ☒ No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? ☐ Yes ☒ No

c Complete the following:

(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals	c(1)	38
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	0
(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))	c(3)	38
(4) Number of nonexcludable employees (line 4c(3)) who are HCEs	c(4)	14
(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan	c(5)	36
(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs	c(6)	14
d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) ▶ _____	d	91.7 %

e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

	Disaggregated part:	Ratio Percentage:	Exception:
(1)			
(2)			
(3)			

f This plan satisfies the coverage requirements on the basis of (check one): (1) ☒ the ratio percentage test (2) ☐ average benefit test

v8.1

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EXHIBIT 75

2

Form **5500**

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

► Complete all entries in accordance with the instructions to the Form 5500.

Official Use Only
OMB Nos. 1210 - 0110
1210 - 0089

2004

This Form is Open to Public Inspection.

Part I Annual Report Identification Information

For the calendar plan year 2004 or fiscal plan year beginning , and ending ,

A This return/report is for: (1) ☐ a multiemployer plan; (2) ☒ a single-employer plan (other than a multiple-employer plan); (3) ☐ a multiple-employer plan; or (4) ☐ a DFE (specify) _____

B This return/report is: (1) ☐ the first return/report filed for the plan; (2) ☐ an amended return/report; (3) ☐ the final return/report filed for the plan; (4) ☐ a short plan year return/report (less than 12 months).

C If the plan is a collectively-bargained plan, check here .....

D If filing under an extension of time or the DFVC program, check box and attach required information. (see instructions) ► ☒

Part II Basic Plan Information — enter all requested information.

1a Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE PLAN

1b Three-digit plan number (PN) ► 002

1c Effective date of plan (mo., day, yr.) 04/01/1976

2a Plan sponsor's name and address (employer, if for a single-employer plan)
(Address should include room or suite no.)
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

769 NORTHFIELD AVENUE

WEST ORANGE NJ 07052-0000

2b Employer Identification Number (EIN) 22-2323990

2c Sponsor's telephone number 973-731-9442

2d Business code (see instructions) 621111

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report. If it is being filed electronically, and to the best of my knowledge and belief, it is true, correct and complete.

SIGN HERE — Signature of plan administrator — Date 10/14/05 — MARIO CRISCITO, M.D. — Type or print name of individual signing as plan administrator

SIGN HERE — Signature of employer/plan sponsor/DFE — Date 10/14/05 — MARIO CRISCITO, M.D. — Type or print name of individual signing as employer, plan sponsor or DFE

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500. v7.2 Form **5500** (2004)

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SCHEDULE I (Form 5500)
Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Financial Information – Small Plan

This schedule is required to be filed under Section 104 of the Employee Retirement Income Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2004

This Form is Open to Public Inspection.

For calendar year 2004 or fiscal plan year beginning , and ending .

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHA

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number 22-2323990

Complete Schedule I if the plan covered fewer than 100 participants as of the beginning of the plan year. You may also complete Schedule I if you are filing as a small plan under the 80-120 participant rule (see instructions). Complete Schedule H if reporting as a large plan or DFE.

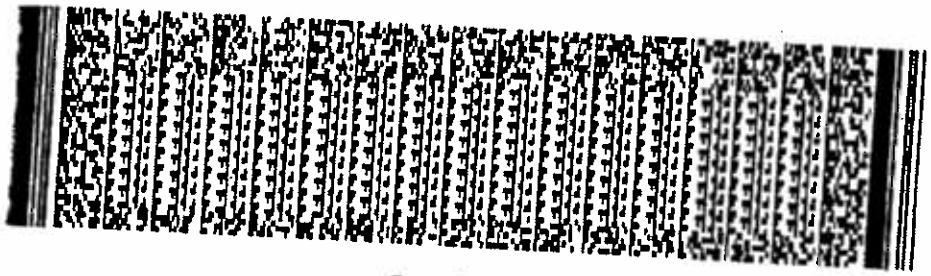
Part I Small Plan Financial Information

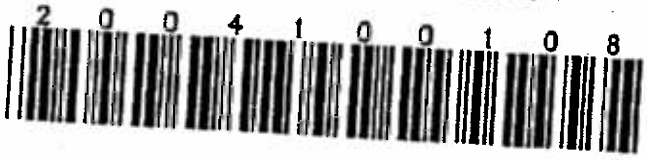
Report below the current value of assets and liabilities, income, expenses, transfers and changes in net assets during the plan year. Combine the value of plan assets held in more than one trust. Do not enter the value of the portion of an insurance contract that guarantees during this plan year to pay a specific dollar benefit at a future date. Include all income and expenses of the plan including any trust(s) or separately maintained fund(s) and any payments/receipts to/from insurance carriers. Round off amounts to the nearest dollar.

		(a) Beginning of Year	(b) End of Year
1 Plan Assets and Liabilities:			
a Total plan assets	1a	8462930	9565020
b Total plan liabilities	1b	0	0
c Net plan assets (subtract line 1b from line 1a)	1c	8462930	9565020
2 Income, Expenses, and Transfers for this Plan Year:		(a) Amount	(b) Total
a Contributions received or receivable (1) Employers	2a(1)	767706	
(2) Participants	2a(2)		
(3) Others (including rollovers)	2a(3)		
b Noncash contributions	2b		
c Other income	2c	376384	
d Total income (add lines 2a(1), 2a(2), 2a(3), 2b, and 2c)	2d		1144090
e Benefits paid (including direct rollovers)	2e		
f Corrective distributions (see instructions)	2f		
g Certain deemed distributions of participant loans (see instructions)	2g		
h Other expenses	2h	42000	
i Total expenses (add lines 2e, 2f, 2g, and 2h)	2i		42000
j Net income (loss) (subtract line 2i from line 2d)	2j		1102090
k Transfers to (from) the plan (see instructions)	2k		

3 Specific Assets: If the plan held assets at anytime during the plan year in any of the following categories, check "Yes" and enter the current value of any assets remaining in the plan as of the end of the plan year. Allocate the value of the plan's interest in a commingled trust containing the assets of more than one plan on a line-by-line basis unless the trust meets one of the specific exceptions described in the instructions.

		Yes	No	Amount
a Partnership/joint venture interests	3a		X	
b Employer real property	3b		X	





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3a Plan administrator's name and address (If same as plan sponsor, enter "Same")
SAME

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report below:
a Sponsor's name

b EIN

c PN

5 Preparer information (optional) a Name (including firm name, if applicable) and address
AMERICAN PENSION CORPORATION

1375 PLAINFIELD AVENUE

WATCHUNG NJ 07069-0000

b EIN
22-2141197

c Telephone number
908-757-5151

6 Total number of participants at the beginning of the plan year	6	49
7 Number of participants as of the end of the plan year (welfare plans complete only lines 7a, 7b, 7c, and 7d)		
a Active participants	7a	45
b Retired or separated participants receiving benefits	7b	0
c Other retired or separated participants entitled to future benefits	7c	4
d Subtotal. Add lines 7a, 7b, and 7c	7d	49
e Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	7e	0
f Total. Add lines 7d and 7e	7f	49
g Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	7g	49
h Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	7h	0
i If any participant(s) separated from service with a deferred vested benefit, enter the number of separated participants required to be reported on a Schedule SSA (Form 5500)	7i	0

8 Benefits provided under the plan (complete 8a and 8b as applicable)

a [X] Pension benefits (check this box if the plan provides pension benefits and enter the applicable pension feature codes from the List of Plan Characteristics Codes printed in the instructions): 2C 2R 3E

b [ ] Welfare benefits (check this box if the plan provides welfare benefits and enter the applicable welfare feature codes from the List of Plan Characteristics Codes printed in the instructions):

9a Plan funding arrangement (check all that apply)
(1) [X] Insurance
(2) [ ] Code section 412(i) insurance contracts
(3) [X] Trust
(4) [ ] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)
(1) [X] Insurance
(2) [ ] Code section 412(i) insurance contracts
(3) [X] Trust
(4) [ ] General assets of the sponsor

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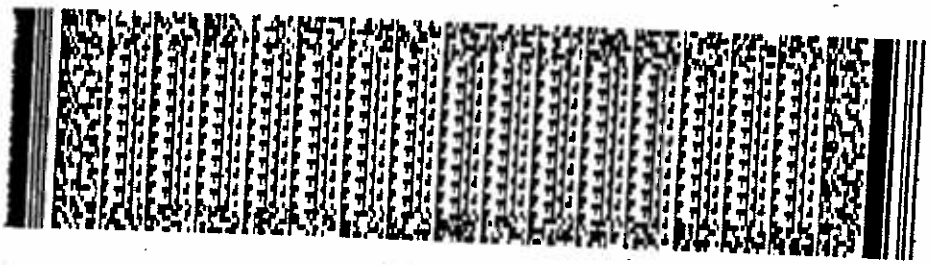
10 Schedules attached (Check all applicable boxes and, where indicated, enter the number attached. See instructions.)

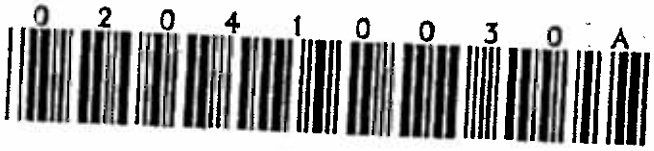
a Pension Benefit Schedules

(1)	[X]	R	(Retirement Plan Information)
(2)	[X] 1	T	(Qualified Pension Plan Coverage Information)
	If a Schedule T is not attached because the plan is relying on coverage testing information for a prior year, enter the year ▶		
(3)	[ ]	B	(Actuarial Information)
(4)	[ ]	E	(ESOP Annual Information)
(5)	[ ]	SSA	(Separated Vested Participant Information)

b Financial Schedules

(1)	[ ]	H	(Financial Information)
(2)	[X]	I	(Financial Information – Small Plan)
(3)	[X] 1	A	(Insurance Information)
(4)	[ ]	C	(Service Provider Information)
(5)	[ ]	D	(DFE/Participating Plan Information)
(6)	[ ]	G	(Financial Transaction Schedules)
(7)	[X] 1	P	(Trust Fiduciary Information)





SCHEDULE R (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Retirement Plan Information

This schedule is required to be filed under sections 104 and 4065 of the Employee Retirement Security Act of 1974 (ERISA) and section 6058(a) of the Internal Revenue Code (the Code).

▶ File as an Attachment to Form 5500.

Official Use Only

OMB No. 1210-0110

2004

This Form is Open to Public Inspection.

For calendar year 2004 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHAS

B Three-digit plan number ▶ 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number
22-2323990

Part I Distributions

All references to distributions relate only to payments of benefits during the plan year.

1 Total value of distributions paid in property other than in cash or the forms of property specified in the instructions ..... 1 $ [redacted]

2 Enter the EIN(s) of payor(s) who paid benefits on behalf of the plan to participants or beneficiaries during the year (if more than two, enter EINs of the two payors who paid the greatest dollar amounts of benefits). _____

Profit-sharing plans, ESOPs, and stock bonus plans, skip line 3.

3 Number of participants (living or deceased) whose benefits were distributed in a single sum, during the plan year ..... 3 [redacted]

Part II Funding Information (If the plan is not subject to the minimum funding requirements of section 412 of the Internal Revenue Code or ERISA section 302, skip this Part)

4 Is the plan administrator making an election under Code section 412(c)(8) or ERISA section 302(c)(8)? ..... ☐ Yes ☒ No ☐ N/A

If the plan is a defined benefit plan, go to line 7.

5 If a waiver of the minimum funding standard for a prior year is being amortized in this plan year, see instructions, and enter the date of the ruling letter granting the waiver ..... ▶ Month _____ Day _____ Year _____

If you completed line 5, complete lines 3, 9, and 10 of Schedule B and do not complete the remainder of this schedule.

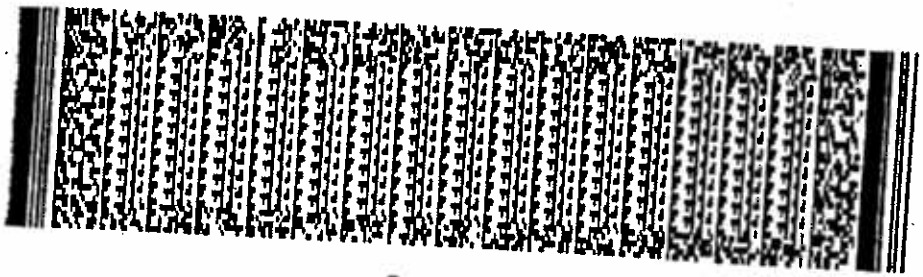
6a	Enter the minimum required contribution for this plan year	6a	$ 767706
b	Enter the amount contributed by the employer to the plan for this plan year	6b	$ 767706
c	Subtract the amount in line 6b from the amount in line 6a. Enter the result (enter a minus sign to the left of a negative amount)	6c	$ 0

If you completed line 6c, do not complete the remainder of this schedule.

7 If a change in actuarial cost method was made for this plan year pursuant to a revenue procedure providing automatic approval for the change or a class ruling letter, does the plan sponsor or plan administrator agree with the change? ..... ☐ Yes ☐ No ☐ N/A

Part III Amendments

8 If this is a defined benefit pension plan, were any amendments adopted during this plan year that increased the value of benefits? (see instructions) ..... ☐ Yes ☐ No



SCHEDULE T (Form 5500)

Department of the Treasury
Internal Revenue Service

Qualified Pension Plan Coverage Information

This form is required to be filed under section 6058(a) of the Internal Revenue Code (the Code).

► File as an attachment to Form 5500.

Official Use Only
OMB No. 1210-0110

2004

This Form is Open to Public Inspection.

For calendar year 2004 or fiscal plan year beginning _____ and ending _____

A Name of plan
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A. MONEY PURCHASE

B Three-digit plan number ► 002

C Plan sponsor's name as shown on line 2a of Form 5500
DIAGNOSTIC & CLINICAL CARDIOLOGY, P.A.

D Employer Identification Number 22-2323990

Note: If the plan is maintained by:

- More than one employer and benefits employees who are not collectively-bargained employees, a separate Schedule T may be required for each employer (see the instruction for line 1).
- An employer that operates qualified separate lines of business (QSLOBs) under Code section 414(r), a separate Schedule T may be required for each QSLOB (see the instruction for line 2).

1 If this schedule is being filed to provide coverage information regarding the noncollectively bargained employees of an employer participating in a plan maintained by more than one employer, enter the name and EIN of the participating employer:

1a Name of participating employer

1b Employer identification number

2 If the employer maintaining the plan operates QSLOBs, enter the following information:

a The number of QSLOBs that the employer operates is _____.

b The number of such QSLOBs that have employees benefiting under this plan is _____.

c Does the employer apply the minimum coverage requirements to this plan on an employer-wide rather than a QSLOB basis? ... ☐ Yes ☐ No

d If the entry on line 2b is two or more and line 2c is "No," identify the QSLOB to which the coverage information given on line 3 or 4 relates. ►

3 Exceptions -- Check the box before each statement that describes the plan or the employer. Also see instructions. If you check any box, do not complete the rest of this Schedule.

a ☐ The employer employs only highly compensated employees (HCEs).

b ☐ No HCEs benefited under the plan at anytime during the plan year.

c ☐ The plan benefits only collectively-bargained employees.

d ☐ The plan benefits all nonexcludable nonhighly compensated employees of the employer (as defined in Code sections 414(b), (c), and (m)), including leased employees and self-employed individuals.

e ☐ The plan is treated as satisfying the minimum coverage requirements under Code section 410(b)(5)(C).

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4 Enter the date the plan year began for which coverage data is being submitted. Month 01 Day 01 Year 2004

a Did any leased employees perform services for the employer at any time during the plan year? ☐ Yes ☒ No

b In testing whether the plan satisfies the coverage and nondiscrimination tests of Code sections 410(b) and 401(a)(4), does the employer aggregate plans? ☐ Yes ☒ No

c Complete the following:

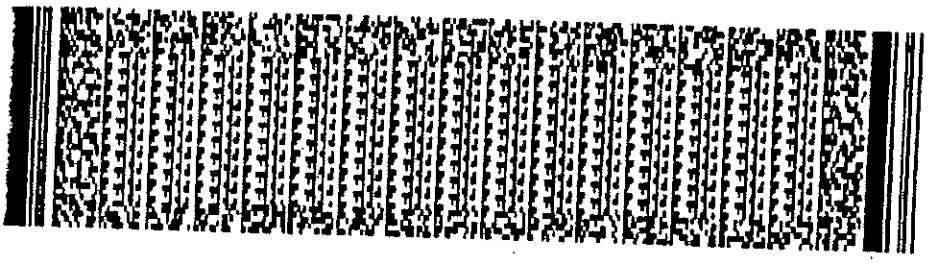
(1) Total number of employees of the employer (as defined in Code section 414(b), (c), and (m)), including leased employees and self-employed individuals	c(1)	46
(2) Number of excludable employees as defined in IRS regulations (see instructions)	c(2)	1
(3) Number of nonexcludable employees. (Subtract line 4c(2) from line 4c(1))	c(3)	45
(4) Number of nonexcludable employees (line 4c(3)) who are HCEs	c(4)	15
(5) Number of nonexcludable employees (line 4c(3)) who benefit under the plan	c(5)	44
(6) Number of benefiting nonexcludable employees (line 4c(5)) who are HCEs	c(6)	15

d Enter the plan's ratio percentage and, if applicable, identify the disaggregated part of the plan to which the information on lines 4c and 4d pertains (see instructions) ▶ _____ d 96.7 %

e Identify any disaggregated part of the plan and enter the ratio percentage or exception (see instructions).

	Disaggregated part:	Ratio Percentage:	Exception:
(1)			
(2)			
(3)			

f This plan satisfies the coverage requirements on the basis of (check one): (1) ☒ the ratio percentage test (2) ☐ average benefit test



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			Yes	No	Amount
3c	Real estate (other than employer real property)	3c		X	
d	Employer securities	3d		X	
e	Participant loans	3e		X	
f	Loans (other than to participants)	3f		X	
g	Tangible personal property	3g		X	

Part II Transactions During Plan Year

			Yes	No	Amount
4	During the plan year:				
a	Did the employer fail to transmit to the plan any participant contributions within the time period described in 29 CFR 2510.3-102? (See instructions and DOL's Voluntary Fiduciary Correction Program)	4a		X	
b	Were any loans by the plan or fixed income obligations due the plan in default as of the close of the plan year or classified during the year as uncollectible? Disregard participant loans secured by the participants' account balance	4b		X	
c	Were any leases to which the plan was a party in default or classified during the year as uncollectible?	4c		X	
d	Were there any nonexempt transactions with any party-in-interest? (Do not include transactions reported on line 4a.)	4d		X	
e	Was the plan covered by a fidelity bond?	4e	X		350000
f	Did the plan have a loss, whether or not reimbursed by the plan's fidelity bond, that was caused by fraud or dishonesty?	4f		X	
g	Did the plan hold any assets whose current value was neither readily determinable on an established market nor set by an independent third party appraiser?	4g		X	
h	Did the plan receive any noncash contributions whose value was neither readily determinable on an established market nor set by an independent third party appraiser?	4h		X	
i	Did the plan at any time hold 20% or more of its assets in any single security, debt, mortgage, parcel of real estate, or partnership/joint venture interest?	4i		X	
j	Were all the plan assets either distributed to participants or beneficiaries, transferred to another plan, or brought under the control of the PBGC?	4j		X	
k	Are you claiming a waiver of the annual examination and report of an independent qualified public accountant (IQPA) under 29 CFR 2520.104-46? If no, attach the IQPA's report or 2520.104-50 statement. (See instructions on waiver eligibility and conditions.)	4k	X		

5a Has a resolution to terminate the plan been adopted during the plan year or any prior plan year? If yes, enter the amount of any plan assets that reverted to the employer this year ☐ Yes ☒ No Amount

5b If during this plan year, any assets or liabilities were transferred from this plan to another plan(s), identify the plan(s) to which assets or liabilities were transferred. (See instructions.)

5b(1) Name of plan(s)	5b(2) EIN(s)	5b(3) PN(s)

2004100209